



ISSUES BRIEF 2009

HEALTH CARE

Working together to reduce health disparities in Minnesota

The Chicano Latino Affairs Council recommends that the Minnesota Governor and Legislature:

- Provide culturally and linguistically appropriate information about new provisions in the health care reform, particularly in the implementation of health prevention programs [Ch.358, S.F. 3780].
- Continue state funding for the Eliminating Health Disparities Initiative (Minnesota Statute Sec. 48.145.928)
- Implement prevention programs (screenings, tests, vaccinations, etc.) in regions with a significant proportion of population at risk.
- Secure the Health Care Access Fund to be used for health care related programs.
- Introduce enforcement rule to Statute 181.73 mandating that employers offer health insurance to migrant agricultural workers.
- Enforce Section 125 Plan procedures for businesses with 11 or more full time employees, allowing them to purchase health insurance with pre-tax dollars (Omnibus Tax Bill [Ch366, H.F 3194]).
- Provide affordable health coverage for everyone in Minnesota, including low-income children and families.

Background

Health care indicators show that Minnesota continues to be one of the healthiest states in the country. Some of the state's strengths include low premature death rate, low infant mortality rate, and low rate of uninsured population. Compared with the rest of the country, Minnesota has one of the highest percentages of employer based insurance (61% vs. 54% nationally). While Minnesota is one of the healthiest states in the country (first from 2002 until 2006, and second in 2007 according to the *2007 America's Health Rankings* report), substantial disparities among minorities exist regarding access to health care and insurance coverage.

In Minnesota, it is estimated that about 374,000 people are uninsured (7.2%), of which 19% are Latinos. Regarding employer coverage by race and ethnicity, very few Latinos and Blacks are covered by their employers when compared to the white population: while 88% of nonelderly white have employer coverage, only 3% of Hispanic and Black have the same type of coverage. In Hennepin County alone, the SHAPE 2006 Survey found that 40% of Hispanic/Latino residents of working age (18-64) lacked health care coverage, the highest of all racial and ethnic groups surveyed. In addition, 29.2% of Latino children surveyed lacked insurance.

The report *Health Disparities Affecting Chicano/Latino Communities in Minnesota* by Comunidades Latinas Unidas en Servicio (CLUES) in 2004 revealed that health disparities affecting Chicano/Latinos were described by the community "as the consequences of multiple factors combined in different ways to different individuals, families, and communities". As such, the study indicates that health disparities were seen as a complex set of parameters as a result of multiple variables, including lack of awareness, poverty, education, health insurance, job conditions, culture and language, immigration status, health promotion and disease prevention.

Between May and August of 2008, CLAC conducted eight focus groups with Latino residents: six in the Twin Cities metro area and two in Greater Minnesota (Willmar and Rochester). 70 participants, nearly all of them Spanish-speaking and foreign born Latinos but with long time roots in Minnesota, gave their input about pressing issues affecting their access to affordable and quality health care,

and the root causes behind health disparities. The main recurrent themes identified as root causes of health disparities in terms of quality of services among urban Latino residents are accessing and navigating the system; communication and awareness of health care information; quality of health services and programs; immigration status. A CLAC survey was distributed statewide during the summer of 2008 through a web service survey to 175 Latino and non-Latino selected experts in the field of health care or working with Latinos in July 2008. CLAC obtained 55% of responses. Regarding the top three issues behind health disparities, respondents identified from a multiple choice matrix the lack of coverage and health insurance (78%), language and cultural barriers (59%), and high costs of health care (53%).

Among the main recommendations for policy makers, many respondents stressed the importance of providing cultural competent services, expanding health care to all residents of Minnesota (some indicating that immigration status should not be an impediment), work early on health prevention with the youth through appropriate curricula at school. Others said that expanding health coverage is a basic human right and is economically sound. As someone stated “good health protects the whole community and prevention saves money in the long run.”

The Minnesota Immigrant Health Task Force’s Report *Immigrant Health: A Call to Action* prepared by the Minnesota Department of Health and the Minnesota Department of Human Services (2005) agreed upon eight essential ways to improve the overall health of immigrants in Minnesota. One of them, maybe the most important according to the group, was to provide equal access for all, regardless of immigration or insurance status. The rationale behind this proposal was that the difference in access to health care between immigrant and non-immigrant exacerbate health disparities. Immigrants do not represent a disproportionate financial burden on the U.S. health care system. According to the American Journal of Public Health (2005), health care expenditures on immigrants were less than half that of U.S.-born citizens (\$2,546 per capita for U.S. born citizens versus \$1,139 per capita for immigrants), including those that were publicly-funded. A 2006 Health Affairs article also indicates that only 6.3% of noncitizens used hospital emergency services in 2003, compared to 31.8% of citizens, despite higher un-insurance rates. According to a 2005 report on the impact of undocumented immigrants in the state by the Minnesota Department of Administration, the Public Assistance Health Care Programs for undocumented immigrants represented \$17 million in FY2005. Taking into consideration that the General Fund of the operating budget totaled \$28,128,405,000 the same year, the referenced health care cost represented only 0.06 percent.

Relevant Legislation

The health care reform bill that passed in 2008 (S.F. 3780, Ch. 358) contains significant advances in many areas, including chronic care management, public health components, and payment reform proposals. It establishes and funds a statewide health improvement program to reduce the percentage of Minnesotans who are obese and reduce the use of tobacco. Although it provided MinnesotaCare coverage for an estimated 8,700 additional people by 2011 and reduced its sliding fee premiums to increase affordability, there still is a need to continue expanding health coverage to vulnerable populations. One important provision is the study and development of a proposal to promote affordable access to employer-sponsored health insurance through the use of direct subsidies and/or tax credits and deductions which should also include industries and sectors that employ large Latino employees. Another positive outcome is the promotion of “health care homes” to coordinate care for people with complex chronic conditions which will require the Department of Health and the Department of Human Services to implement standards of certification by 2009.